STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297103	A. BUILDING _____ B. WING _____	06/22/2010

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WESTERN HOME CARE	4035 E POST RD LAS VEGAS, NV 89120

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G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your agency from 6/15/10 through 6/22/10, in accordance with 42 CFR Part 484 - Home Health Services. The active census on the first day of the survey was 182. Forty clinical records were reviewed including four closed records. Twenty-five home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The agency failed to maintain compliance with the following Condition of Participation: 42 CFR 484.14 - Organization, services, and administration The following regulatory deficiencies were identified.	G 000		
G 102	484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to provide a written notice of patients' rights	G 102		8/13/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 102	Continued From page 1 in advance of furnishing care for 2 of 8 Medicare patients receiving home visits (Patients #7 and #18). Findings include: On 6/15/10, an example of the agency's admission packet for Medicare patients was reviewed. There were no documents in the packet which explained the Outcome and Assessment Information Set (OASIS) collection and reporting information and the patient's rights in regard to OASIS data. On 6/15/10 at 1:45 PM, the Director of Clinical Services reviewed the Medicare admission packet and was unable to find documents which explained OASIS rights. On 6/16/10, home visits were made to Patients #7 and #18. When asked about OASIS information, the patients and/or spouses indicated they were not informed about collection of OASIS information. A review of the patients' in home folders failed to produce written information regarding OASIS information collection, reporting, and the patient's rights in regards to OASIS data.	G 102		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the agency failed to ensure staff followed acceptable standards of practice in the area of	G 121		8/13/10

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G 121	Continued From page 2	G 121		

infection control while providing care for 2 of 25 patients (Patients #3 and #5) and failed to ensure staff obtained a physician's signature in a timely manner for 1 of 25 patients (Patient #5).

Findings include:

Patient #3

Patient #3 was admitted on 5/27/10, with diagnoses including gangrene of the left foot fifth toe and uncontrolled insulin dependent diabetes mellitus.

On 6/16/10 in the morning during a home visit, the registered nurse (RN) removed her gloves a total of nine times while providing wound care. Of the nine opportunities to perform hand hygiene after the removal of the gloves, the RN failed to do so five times.

After the wound care, the RN changed the dressing on Patient #3's PICC (peripherally inserted central catheter). The RN opened the sterile dressing change kit and set the mask aside, explaining, "We were told we no longer need to wear a mask for this procedure."

On 6/22/10 during an interview with the Director of Clinical Services (DCS), the DCS indicated she would expect clinical staff to perform hand hygiene after removing gloves.

On 6/23/10 in the morning, a conversation with the DCS confirmed the staff "...were told by their counterpart in Arizona that wearing a mask for a PICC dressing change was optional..."

Patient #5

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G 121	Continued From page 3 Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity. On 6/17/10 in the morning during a home visit, the registered nurse (RN) retrieved items from the nursing bag several different times without first performing hand hygiene. After washing her hands on two occasions during the course of the visit, the RN turned off Patient #5's kitchen faucet with a bare hand. The agency's 2000 Infection Control Policy, revised 6/1/08, indicated, "The Agency's infection control procedures are based on universally accepted principles of infection control ... Hand washing is to be performed: ... - After removing gloves ... 8. Use paper towels to turn off faucets... - Hand washing is to be performed ... before placing hands inside the Home Care Bag. If additional supplies are needed during the visit, wash hands BEFORE moving supplies from the bag ..." The standards in Home Care Nursing Practice: Concepts and Applications by Robyn Rice, PhD, RN, indicated, " ...Wash hands with liquid soap and water immediately after removing gloves. If soap and water are not available, antiseptic hand cleanser or towelettes may be used. Hands should then be washed with soap and water as soon as possible ... Do not reenter the (nursing) bag unless your hands are clean ... "	G 121		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 122		8/13/10

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G 122	Continued From page 4 This CONDITION is not met as evidenced by: Based on observation, interview, record and document review, the agency failed to ensure: the governing body assumed legal authority and responsibility for the agency's operations (G128); the administrator organized and directed the agency's functions (G133); the agency employed qualified staff and the administrator ensured staff evaluations (G134); the agency had written contracts between personnel and agency (G142); that all personnel furnishing services maintained liaison to ensure their efforts were coordinated effectively and supported the objectives outline in the plan of care (G143); a written summary was sent to the physician at least every 60 days (G145) and, the agency was certified for level of laboratory testing performed (G150). The cumulative effect of these systemic practices resulted in the failure of the agency to adequately provide necessary services for the care and safety of its patients.	G 122		
G 128	484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. This STANDARD is not met as evidenced by: Based on observation, interview, record and document review, the governing body failed to assume full legal authority and responsibility for the operation of the agency. Findings include:	G 128		8/13/10

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G 128	Continued From page 5 The agency was not in compliance with the following Condition of Participation: 42 CFR 484.14 - Organization, services, and administration which included: G133-the administrator organized and directed the agency's functions; G134- the agency employed qualified staff and the administrator ensured staff evaluations; G142- the agency had written contracts between personnel and agency; G143-all personnel furnishing services maintained liaison to ensure their efforts were coordinated effectively and supported the objectives outline in the plan of care; G145- a written summary was sent to the physician at least every 60 days; and, G150- the agency was certified for level of laboratory testing performed. Other regulatory deficiencies identified included: G102-notice of patient rights prior to treatment; G121-all staff comply with professional standards; G157-patients are accepted on the basis of a reasonable expectation all their medical, nursing and social needs can be met in their residence by the agency; G158-care follows a written plan of care established by the physician; G159-plan of care covers all pertinent diagnoses and equipment; G165-care provided conforms with physician's orders; G166-verbal orders are put in writing, signed and dated; G170-nursing services are provided in accordance with the plan of care;	G 128		

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G 128	Continued From page 6 G172-The Registered Nurse regularly re-evaluates the patient's nursing needs; G176-The Registered Nurse informed the physician of changes in the patient's condition requiring a change in the plan of care; G178-The Registered Nurse provided teaching to patients; G214-annual performance reviews were done for the home health aides; G215-the agency documented 12 hours of inservice per year for the home health aides; G236-clinical records were maintained in accordance with professional standards; G332-initial comprehensive assessments were conducted within 48 hours of referral to the agency; and, G337-comprehensive assessments of the patient's medications were conducted.	G 128		
G 133	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on observation, interview, record and document reviews, the administrator failed to organize and direct the agency's ongoing functions. Findings include: The agency was not in compliance with the following Condition of Participation:	G 133		8/13/10

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G 133	Continued From page 7 42 CFR 484.14 - Organization, services, and administration which included: G133-the administrator organized and directed the agency's functions; G134- the agency employed qualified staff and the administrator ensured staff evaluations; G142- the agency had written contracts between personnel and agency; G143-all personnel furnishing services maintained liaison to ensure their efforts were coordinated effectively and supported the objectives outline in the plan of care; G145- a written summary was sent to the physician at least every 60 days; and, G150- the agency was certified for level of laboratory testing performed (G150). Other regulatory deficiencies identified included: G102-notice of patient rights prior to treatment; G121-all staff comply with professional standards; G157-patients are accepted on the basis of a reasonable expectation all their medical, nursing and social needs can be met in their residence by the agency; G158-care follows a written plan of care established by the physician; G159-plan of care covers all pertinent diagnoses and equipment; G165-care provided conforms with physician's orders; G166-verbal orders are put in writing, signed and dated; G170-nursing services are provided in accordance with the plan of care; G172-The Registered Nurse regularly re-evaluates the patient's nursing needs; G176-The Registered Nurse informed the physician of changes in the patient's condition	G 133		

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G 133	Continued From page 8 requiring a change in the plan of care; G178-The Registered Nurse provided teaching to patients; G214-annual performance reviews were done for the home health aides; G215-the agency documented 12 hours of inservice per year for the home health aides; G236-clinical records were maintained in accordance with professional standards; G332-initial comprehensive assessments were conducted within 48 hours of referral to the agency; and, G337-comprehensive assessments of the patient's medications were conducted.	G 133		
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on record review and interview, the agency's administrator failed to ensure the completion of staff evaluations for 4 of 10 employees (Employees #1, #2, #5, and #9). Findings include: On 6/22/10 in the afternoon, the director of clinical services provided an employee information guide, last revised 7/1/03. According to the section entitled "annual evaluation,", "employees will be evaluated by their supervisor on an as needed, periodic basis, but at least annually." The following four employees worked since 11/10/08: Employees #1, #2, #5, and #9.	G 134		8/13/10

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G 134	Continued From page 9 On 6/15/10, a review of personnel files revealed the four aforementioned employees lacked performance evaluations. On 6/15/10 at 4:30 PM, the Director of Clinical Services was informed of the missing evaluations. On 6/18/10 in the afternoon, the office manager failed to provide any of the missing evaluations. On 6/22/10 in the afternoon, agency staff failed to provide any of the missing evaluations.	G 134		
G 142	484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.	G 142		8/13/10

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G 142	Continued From page 10 This STANDARD is not met as evidenced by: Based on interview document review, and policy review, the agency failed to have a written contract between contracted personnel and the agency for 2 of 2 contracted personnel. Findings include: On 6/15/10, at 9:15 AM, during the entrance conference, the Director of Clinical Services (DCS) indicated the agency had two contracted staff, a physical therapist (PT) and a Registered Nurse (RN). When asked to provide the contracts for these entities, the DCS provided a "Salary History Report" for the PT and a "Contracted rate per visit" form for the RN. The DCS stated these were the only contract forms the agency had. The agency's policy titled, "Fee for Service Contract" with a revised date of 3/1/09, read, "Personnel under hourly or per-visit contracts shall have such contracts established, written, and maintained by WHC. Contracts shall conform to provisions for it contained in the Conditions of Participation for Home Health Agencies and/or state regulations and shall be reviewed and/or renewed annually or according to the renewal terms of the contract." The policy further stated, "The contract must: A. Provide for retention by the primary agency of responsibility for and control of the services. B. Designate the services, which are to be provided, the setting and the geographical area served. C. Describe how the contracted personnel are to be supervised.	G 142		

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G 142	Continued From page 11 D. Describe how services are coordinated with the primary agency. E. Provide for the reporting of clinical notes and observations by the contracted personnel for inclusion in the records of the primary home health agency to facilitate planning and evaluating patient care and to document the care given. Periodic progress notes by appropriate members of the staff must be submitted every 14 days and more often if warranted by the patient's condition. F. Specify the method of determining charges and reimbursement by WHC for specific services provided under contract. Only the primary agency may bill for or collect for services. G. Specify the period of time the contract is to be in effect and how frequently it is to be reviewed. The contract must be reviewed annually. H. Assure that personnel and services, contracted for meet the requirements specified in NAC 449.749 to 449.800, inclusive, for home health agency personnel and services, including licensure, personnel qualifications, medical examination, functions, supervision, orientation, in-service education and case conferences. I. Provide for the acceptance of the patients for home health service only by WHC. Patients may not be admitted for home health by any person without appropriate review of the case and acceptance of the patient by WHC. J. Assure that personnel and services contracted for will provide treatment to referred patients without regard to race, creed or national origin."	G 142		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.	G 143		8/13/10

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G 143	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the Registered Nurse (RN) conferenced with the home health aide (HHA) to coordinate care and support the objectives outlined in the plan of care for 1 of 6 patients who received aide services (Patient #7). Findings include: Patient #7 Patient #7 was admitted on 3/10/10, with diagnoses including pneumonia, renal failure, and congestive heart failure. For the certification period of 5/9/10 through 7/7/10, the physician ordered the services of the HHA three times a week for four weeks to assist the patient with personal care. Documentation in the record indicated the HHA had not provided visits as ordered to the patient for the weeks of 5/16/10-5/22/10 and 5/23/10-5/29/10, as the patient refused the visits. There was no documentation in Patient #7's record, the RN responsible for the patient's care was aware of the refused HHA services. On 6/16/10 at 4:30 PM, a home visit was made to Patient #7. The patient stated he had not required the assistance of the HHA "for a while as I can shower myself." On 6/17/10 at 8:20 AM, the Director of Clinical Services indicated the RN should have known about the numerous refusals.	G 143		
G 145	484.14(g) COORDINATION OF PATIENT	G 145		8/13/10

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G 145	Continued From page 13 SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on record review, interview and document review, the agency failed to ensure staff prepared and sent the physician a comprehensive 60 day summary which included the patient's status and all issues identified at the beginning of the certification period, wound measurements, blood sugar results/ranges, treatments administered, instructions provided, how the patient responded to instructions and tolerated the treatments, any hospitalizations (to include reason for same), changes in medications and treatments, which goals were met and the overall status at the end of the 60 day period for 2 of 40 patients (Patients #5, #7). Findings include: Patient #5 Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity. Patient #5 required three visits per week for nine weeks for wound care to both lower legs and instructions regarding skin care, blood glucose monitoring, medications, diet and home safety. For the certification period ending 4/28/10, the 60 day summary read "Patient (#5) continues to work to substitute appropriate foods for foods off her	G 145		

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G 145	Continued From page 14 diet. Patient is losing weight and has more energy." The 60 day summary lacked documentation regarding Patient #5's initial bilateral lower extremity edema, the type and amount of drainage, instructions provided and whether the patient followed them, treatments administered, changes made in treatments and medications, status of the bilateral lower extremities edema and drainage at the end of the certification period, blood sugar ranges, and the fact the patient underwent sleep studies, resulting in the addition of CPAP (continuous positive airway pressure) at night. The agency's policy 7/25/07 Plan of Care policy, revised 3/1/09 indicated, " ... H. The Case Manager prepares a physician 60-day summary to be faxed to the physician." Patient #7 Patient #7 was admitted on 3/10/10, with diagnoses including pneumonia, renal failure, and congestive heart failure. The agency received physician's orders to re-certify the patient for services for 5/9/10 through 7/7/10. Patient #7's record lacked documentation indicating a 60 day summary had been written by the Registered Nurse and sent to the physician. On 6/15/10 at 2:10 PM, the Director of Clinical Services (DCS) indicated the 60 day summary was typed on the last page of the certification order form sent to the physician. The DCS reviewed the certification order form sent to the	G 145		

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G 145	Continued From page 15 physician for Patient #7 and stated, "It's not there. That's where it should be."	G 145		
G 150	484.14(j) LABORATORY SERVICES (1) If the HHA engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of part 493 of this chapter. (2) If the HHA chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation and interview, the agency failed to have a current CLIA (Clinical Laboratory Improvement Amendments) Certificate of Waiver. Findings include: On 6/15/10 at 8:05 AM, upon entering the agency, it was noted there was no CLIA Certificate of Waiver on the lobby wall with the agency's other licenses and certificates. On 6/15/10 at 8:15 AM, during the entrance conference, the Director of Clinical Services (DCS) stated the agency's Registered Nurses performed blood glucose monitoring tests and tests for blood clotting in the patient's home. The	G 150		8/13/10

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G 150	Continued From page 16 DCS was asked for a copy of the agency's CLIA Certificate of Waiver which allows those tests to be done by the agency's nurses. On 6/15/10 at 2:10 PM, the DCS indicated the agency's CLIA Certificate of Waiver had expired in September 2009, and had not been renewed. The DCS said she checked with the Nevada state office in charge of CLIA waivers and was told the state office had sent the agency three renewal notices in 2009, but the fees had not been paid. The agency performed waived laboratory tests without the proper certification.	G 150		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the agency failed to ensure evaluations for care were provided by agency personnel in a timely manner for 6 of 40 sampled patients (Patients #7, #9, #10, #25, #11, and #14). Findings include: The agency's policy titled, "Assessments / Reassessments" with a revised date of 3/8/09 read, "...1. Completion of the comprehensive assessment: The initial assessment visit must be conducted either within 48 hours of the referral..."	G 157		11/26/10

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G 157	Continued From page 17 On 6/15/10 at 3:10 PM, the Director of Clinical Services indicated the time frame for secondary services to conduct the evaluation visit was "24-48 hours of the referral." Patient #7 Patient #7 was admitted on 3/10/10, with diagnoses including pneumonia, renal failure, and congestive heart failure. For the certification period of 5/9/10 through 7/7/10, the physician ordered the services of the Occupational Therapist (OT). The OT provided the evaluation visit on 5/15/10, five days after the referral date. Patient #9 Patient #9 was admitted on 11/9/09, with diagnoses including atrial fibrillation and hypertension. Documentation in the record indicated the patient was discharged from the acute care hospital on 11/5/09, at which time the agency received a referral for care. The Registered Nurse (RN) conducted the initial comprehensive assessment on 11/9/09, four days after the receipt of the referral. There was no documentation in Patient #9's record why the RN did not conduct the initial visit within 48 hours of receipt of the referral. There was no documentation the physician was notified of the delay in service. On 6/16/10 at 3:15 PM, the Director of Clinical Services reviewed Patient #9's record and stated, "I don't know why the initial visit was done so late." Patient #10	G 157		

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G 157	Continued From page 18 Patient #10 was admitted on 5/11/10, with diagnoses including cellulitis of the leg, abnormality of gait, and morbid obesity. Documentation in the record indicated the patient was admitted to the acute care hospital on 5/24/10, and discharged from the hospital on 5/28/10. The Registered Nurse (RN) conducted a return to care visit on 5/29/10. A physician's order dated 5/29/10, included orders for Physical Therapy (PT) and Occupational Therapy (OT) to evaluate Patient #10. The OT evaluation was conducted on 6/2/10, four days after the order was obtained. The PT evaluation was conducted 6/3/10, five days after the order was obtained. There was no documentation in the record by the PT or OT as to why the evaluations were not done within the 24-48 hours of the physician's order. There was no documentation in the record the physician was notified of the delay in service. Patient #25 Patient #25 was admitted on 6/11/10, with diagnoses including partial shoulder replacement and abnormality of gait. A physician's order dated 6/11/10, included orders for Occupational Therapy (OT) to evaluate the patient. The OT evaluation was conducted on 6/15/10, four days after the physician's order. There was no documentation in the record by the OT as to why the evaluation was not conducted within 24-48 hours of the physician's order. Patient #11	G 157		

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G 157	Continued From page 19 On 5/25/10, Patient #11 was admitted with diagnoses including critical illness myopathy, gastrostomy, influenza with pneumonia, diabetes mellitus, atrial fibrillation, myasthenia gravis without exacerbation, and new onset hypertension. On 5/25/10, the physician's start of care orders included an occupational therapy evaluation. On 5/29/10, the occupational therapist evaluated the patient. The patient's clinical record lacked documented evidence the occupational therapist notified the physician regarding the delay and the rationale for the delay. Patient #14 On 5/15/10, Patient #14 was admitted with diagnoses including malignant neoplasm main bronchus, diabetes mellitus, hypertension new onset, and hyperlipidemia new onset. On 5/15/10, a physician's verbal order indicated an occupational therapy evaluation. On 5/19/10, the occupational therapist evaluated the patient. The patient's clinical record lacked documented evidence the occupational therapist notified the physician regarding the delay and the rationale for the delay.	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established	G 158		11/26/10

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G 158	Continued From page 20 and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure plans of care established by the ordering physician were followed by staff providing care for 9 of 40 patients (Patients #5, #16, #33, #11, #14, #6, #10, #18, and #26). Findings include: Patient #5 Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity. Patient #5's Plan of Care (POC) for the certification period of 2/28/10 - 4/27/10, read "Skin and foot care to include: Cleanse with normal saline, apply Calamine lotion Kerlix (long gauze wrap) and Ace bandage to secure change every other day..." From 3/4/10 through 4/27/10, the SN notes indicated Calamine lotion was applied to both lower legs followed by Kerlix gauze wrap and secured with tubigrip. Twenty two nursing notes lacked evidence the SN applied the ace bandage as ordered. Patient #5's POC for the certification period of 4/29/10 - 6/27/10, read "Skin and foot care to include: Cleanse with normal saline, apply Calamine lotion Kerlix and Ace bandage to secure change every other day..."	G 158		

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G 158	Continued From page 21 From 4/29/10 through 6/12/10, the SN notes indicated tubigrip was used to secure the kerlix dressing. Twelve nursing notes lacked evidence the SN applied the ace bandage as ordered by the physician. On 6/22/10, the Director of Clinical Services (DCS) confirmed there was "quite a difference" between tubigrip (net dressing) and an ace bandage. Patient #5's POC for the certification period of 4/29/10 through 6/26/10, read "SN: "3W9 (three times a week for nine weeks) with 3 prn (as needed) for complications..." Documentation in Patient #5's clinical record revealed SN saw the patient beginning on 4/29/10, two times a week for two weeks, three times a week for three weeks, once a week for one week and two times a week for one week. There was no documented evidence the physician was notified of the missed visits. There was no physician's order to decrease the frequency of SN visits. Patient #16 Patient #16 was admitted on 5/7/10, with diagnoses including cervical disc degeneration and hypertension. Patient #16's plan of care for the certification period of 5/7/10 through 7/5/10 included orders for skilled nursing to see one time a week for nine weeks with three PRN (as needed) visits for changes with incision.	G 158		

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The registered nurse saw Patient #16 one more time and discharged the patient as of that day (5/12/10). There was no documented evidence the nurse notified the physician and obtained an order to discharge the patient seven weeks early.

Patient #33

Patient #33 was admitted on 5/25/10, with diagnoses including osteoarthritis of the hip, abnormal gait, anxiety and glaucoma.

Patient #33's plan of care indicated skilled nursing was to see the patient two times a week for one week and then one time a week for 8 weeks.

A skilled nursing visit note dated 6/9/10 revealed the registered nurse discharged Patient #33 on the same day. There was no documented evidence the nurse notified the physician and obtained an order to discharge the patient six weeks early.

Patient #11

On 5/25/10, Patient #11 was admitted with diagnoses including critical illness myopathy, gastrostomy, influenza with pneumonia, diabetes mellitus, atrial fibrillation, myasthenia gravis without exacerbation, and new onset hypertension.

On 5/25/10, Patient #11's plan of care included orders for skilled nursing visits twice per week for two weeks and then once per week for seven weeks, physical therapy visits twice per week for one week and then three times per week for four

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G 158	Continued From page 23 weeks, and occupational therapy visits once per week for one week and then twice per week for four weeks. On 5/31/10, the occupational therapist completed a missed visit form. On 6/3/10 and 6/10/10, the physical therapist completed missed visit forms. On 6/4/10, the skilled nurse completed a missed visit form. In each aforementioned case, Patient #11's clinical record lacked documented evidence agency staff notified the physician and/or obtained a physician's order reducing the frequency of visits for the respective weeks and disciplines. Patient #14 On 5/15/10, Patient #14 was admitted with diagnoses including malignant neoplasm main bronchus, diabetes mellitus, hypertension new onset, and hyperlipidemia new onset. On 5/15/10, Patient #14's plan of care included orders for skilled nursing visits once per week for one week, six times per week for one week, three times per week for one week, and then once per week for six weeks. The plan of care included orders for physical therapy visits three times per week for three weeks. The plan of care included orders for occupational therapy visits once per week for four weeks. From 5/23/10 through 5/29/10, a physician ordered three skilled nursing visits for Patient	G 158		

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G 158	Continued From page 24 #14. The clinical record showed the skilled nurse completed visits on 5/23/10 and 5/29/10. The clinical record lacked documented evidence of a third skilled nursing visit. The clinical record lacked a physician's order reducing the frequency of skilled nursing visits. From 5/23/10 through 5/29/10, a physician ordered a once per week occupational therapist visit for Patient #14. The clinical record lacked documented evidence of an occupational therapist visit from 5/23/10 through 5/29/10. The clinical record lacked a physician's order reducing the frequency of occupational therapist visits. On 5/29/10, the physical therapist completed a missed visit form. Patient #14's clinical record lacked documented evidence the physical therapist notified the physician and/or obtained a physician's order reducing the frequency of physical therapist visits. On 6/21/10 in the afternoon, the director of clinical services was informed of Patient #14's aforementioned missing and undocumented visits. Agency staff failed to provide documented evidence reconciling the aforementioned missing and undocumented visit information. Patient #6 Patient #6 was admitted on 4/27/10, with diagnoses including osteoarthritis and hypertension. For the certification period 4/27/10 through 6/25/10, the physician ordered home health aide (HHA) services two times a week for one week and three times a week for two weeks, to assist with personal care.	G 158		

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According to the orders, the HHA was to visit Patient #6 two times the week of 4/27/10. There was no documented evidence in the patient's record HHA visits were made that week. A missed visit report dated 4/29/10, and signed by the HHA indicated a visit was not made on 4/29/10 as the patient had refused. There was no documentation as to why another visit was not made by the HHA that week. There was no documented evidence the physician had been notified of the missed visits.

Patient #10

Patient #10 was admitted on 5/11/10,with diagnoses including cellulitis of the leg, abnormality of gait, and morbid obesity. For the certification period of 5/11/10 through 7/9/10, the physician ordered Physical Therapy (PT) to evaluate the patient.

Documentation in the record indicated Patient #10 was admitted to the acute care hospital on 5/24/10. There was no documentation in the record of a PT evaluation visit conducted from 5/11/10 to 5/24/10. There was no documented evidence the physician was made aware PT services had not been provided as ordered.

On 6/16/10 at 3:10 PM, the Director of Clinical Services (DCS) reviewed Patient #10's record and was unable to find documentation of a PT evaluation. The DCS stated, "The referral to PT should have been done by the intake person."

Patient #18

Patient #18 was admitted on 5/1/10, with diagnoses including pressure ulcer, neurogenic

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G 158	Continued From page 26 bladder and quadriplegia. For the certification period of 5/1/10 through 6/29/10, the physician ordered home health aide (HHA) services three times a week for nine weeks beginning 5/5/10, to assist with personal care. Documentation in the record indicated the HHA visited Patient #18 one time in the first week. There was no documentation as to why two visits were not made. There was no documentation the physician was notified of the missed visits. Patient #26 Patient #26 was admitted on 6/11/10, with diagnoses including degenerative joint disease and diabetes. The patient had a total knee replacement. A physician's order dated 6/11/10, included orders for Occupational Therapy (OT). There was no documented evidence the OT conducted an evaluation visit. On a Physical Therapy (PT) visit note dated 6/17/10, the PT indicated there was no need for OT services. There was no documentation the PT discussed the findings with the physician. There was no documented evidence the physician discontinued the order for OT services. On 6/18/10 at 9:50 AM, the Director of Clinical Services stated the PT should have contacted the physician to discontinue the OT service order.	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.	G 165		8/13/10

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This STANDARD is not met as evidenced by:
Based on record review, interview and document review, the agency failed to ensure treatments were administered only as ordered by the physician for 3 of 40 patients (Patients #3, #5 and #18).

Findings include:

Patient #3

Patient #3 was admitted on 5/27/10 with diagnoses including gangrene of the left foot fifth toe and uncontrolled insulin dependent diabetes mellitus.

According to documentation on skilled nursing visit notes (SNVN) in Patient #3's clinical record, the registered nurse "applied Adaptic (non-adherent dressing) to the wound bed" on three occasions.

The 6/7/10 SNVN revealed the nurse contacted the physician and "discussed using Adaptic" on Patient #3's post surgical foot wound.

On 6/16/10 in the morning during a home visit, the registered nurse placed Adaptic (a non-adherent dressing) on the exposed bone of Patient #3's left foot wound.

Patient #3's clinical record lacked documented evidence of a physician's order to use Adaptic in the patient's wound.

Patient #5

Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure,

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G 165	Continued From page 28 bilateral lower extremity edema, hypertension and obesity. On 6/17/10 in the morning during a home visit, Patient #5 had a CPAP (continuous positive airway pressure) machine which was not listed on the Plan of Care. The patient indicated she got the machine "about two months ago" and used it during the night. Patient #5's Plan of Care (POC) for the certification period of 2/28/10 - 4/27/10 read "Skin and foot care to include: Cleanse with normal saline, apply Calamine lotion Kerlix (long gauze wrap) and Ace bandage to secure ..." Patient #5's clinical record included eight SN notes revealing the patient's feet and legs were cleaned/soaked in EPSOM SALTS prior to the SN applying calamine lotion, kerlix and Tubigrip to secure. Two SNVN in Patient #5's clinical record revealed the patient's feet and legs were cleansed with water and a brush due to the fact normal saline was unavailable. Patient #5's clinical record lacked a physician's order for skin/wound care to include tubigrip (net dressing), warm water baths, warm water baths with Epsom salts and the use of a brush. There was no evidence SN contacted the physician to request orders for these changes to the plan of care. On 6/22/10, the Director of Clinical Services (DCS) confirmed there was "quite a difference" between tubigrip (net dressing) and an ace bandage/wrap.	G 165		

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G 165	Continued From page 29 Patient #5's Recertification Orders dated 4/27/10 and the Plan of Care for the certification period of 4/29/10 - 6/27/10 lacked a physician's signature as of 6/22/10. Patient #18 Patient #18 was admitted on 5/1/10, with diagnoses including pressure ulcer, neurogenic bladder and quadriplegia. Documentation in the record indicated the patient was admitted to service with a urinary catheter in place. Documentation in Patient #18's record indicated the Registered Nurse changed the urinary catheter on 5/10 and 5/31/10. There was no documented evidence of a physician's order to change the urinary catheter. On 6/21/10 at 8:50 AM, the Director of Clinical Services (DCS) acknowledged there was no physician order to change Patient #18's catheter. The DCS stated, "I will let the nurse know."	G 165		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on record review, interview, and document review, the agency failed to ensure the Registered Nurse (RN) ensured skilled nursing services were provided in accordance with the plan of care for 4 of 40 sampled patients (Patient #6, #18, #11, and #14). Findings include:	G 170		8/13/10

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G 170	Continued From page 30	G 170		

Patient #6

Patient #6 was admitted on 4/27/10, with diagnoses including osteoarthritis and hypertension. For the certification period 4/27/10 through 6/25/10, the physician ordered home health aide (HHA) services two times a week for one week and three times a week for two weeks, to assist with personal care.

According to the orders, the HHA was to visit Patient #6 two times the week of 4/27/10. There was no documented evidence HHA visits were made. A missed visit report dated 4/29/10, and signed by the HHA indicated a visit was not made on 4/29/10 as the patient had refused. There was no documentation as to why another visit was not made by the HHA that week. There was no documented evidence the physician had been notified of the missed visits.

Patient #18

Patient #18 was admitted on 5/1/10, with diagnoses including pressure ulcer, neurogenic bladder and quadriplegia. For the certification period of 5/1/10 through 6/29/10, the physician ordered home health aide (HHA) services three times a week for nine weeks beginning 5/5/10, to assist with personal care.

Documentation in Patient #18's record indicated the HHA visited one time in the first week. There was no documentation as to why two visits were not made. There was no documentation the physician was notified of the missed visits.

Patient #18 was admitted to service with a urinary

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G 170	Continued From page 31 catheter in place. Documentation in the record indicated the Registered Nurse changed Patient #18's urinary catheter on 5/10 and 5/11/10. There was no documented evidence of a physician's order to change the urinary catheter. On 6/21/10 at 8:50 AM, the Director of Clinical Services (DCS) acknowledged there was no physician order to change Patient #18's catheter. The DCS stated, "I will let the nurse know." Patient #11 On 5/25/10, Patient #11 was admitted with diagnoses including critical illness myopathy, gastrostomy, influenza with pneumonia, diabetes mellitus, atrial fibrillation, myasthenia gravis without exacerbation, and new onset hypertension. On 5/25/10, Patient #11's plan of care included orders for skilled nursing visits twice per week for two weeks and then once per week for seven weeks. On 6/4/10, the skilled nurse completed a missed visit form for Patient #11. Patient #11's clinical record lacked documented evidence the skilled nurse notified the physician and/or obtained a physician's order reducing the frequency of skilled nursing visits. Patient #14 On 5/15/10, Patient #14 was admitted with diagnoses including malignant neoplasm main bronchus, diabetes mellitus, hypertension new	G 170		

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G 170	Continued From page 32 onset, and hyperlipidemia new onset. On 5/15/10, Patient #14's plan of care included orders for skilled nursing visits once per week for one week, six times per week for one week, three times per week for one week, and then once per week for six weeks. From 5/23/10 through 5/29/10, a physician ordered three skilled nursing visits. Patient #14's clinical record showed the skilled nurse completed visits on 5/23/10 and 5/29/10. Patient #14's clinical record lacked documented evidence of a third skilled nursing visit. Patient #14's clinical record lacked a physician's order reducing the frequency of skilled nursing visits. On 6/21/10 in the afternoon, the Director of Clinical Services was informed of Patient #14's aforementioned missing and undocumented visits. Agency staff failed to provide documented evidence reconciling the aforementioned missing and undocumented visit information. The agency's 7/25/07 Plan of Care policy, revised 3/1/09, revealed "... Home Care Services are provided to patients: A. In accordance with a plan of care established and authorized by a physician's (doctor of medicine, osteopathy or podiatry) written orders. B. Following a written plan of care established and periodically reviewed by the physician...Modifications to the Plan of Care: A. The agency promptly informs the physician of any changes in the patient's condition that may require modification of the plan of care..."	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE	G 172		8/13/10

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G 172	Continued From page 33 The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure the registered nurse regularly re-evaluated the needs of 2 of 40 patients (Patients #5 and #7). Findings include: Patient #5 Patient #5 was admitted on 2/28/10, with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity. On 6/17/10 in the morning during a home visit, Patient #5 was asked which medications she was taking. The patient revealed she had run out of four medications "2 - 3 weeks ago" and was not planning to refill one of them because "they're too expensive." When interviewed about having a social worker come out and assess for eligibility of community resources, Patient #5 indicated this was not mentioned to her by her regular nurse (who was unavailable during the survey). The registered nurse failed to re-evaluate Patient #5's needs for a social worker. Patient #7 Patient #7 was admitted on 3/10/10, with	G 172		

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G 172	Continued From page 34 diagnoses including pneumonia, renal failure, and congestive heart failure. For the certification period of 5/9/10 through 7/7/10, the physician ordered the services of the HHA three times a week for four weeks to assist the patient with personal care. Documentation in the record indicated the HHA had not provided visits as ordered to the patient for the weeks of 5/16/10-5/22/10 and 5/23/10-5/29/10, as the patient refused the visits. Patient #7's record lacked documentation indicating the registered nurse (RN) responsible for the patient's care was aware the patient had refused HHA services. On 6/16/10 at 4:30 PM, a home visit was made to Patient #7. The patient stated he had not required the assistance of the HHA "for a while as I can shower myself." On 6/17/10 at 8:20 AM, the Director of Clinical Services indicated the RN should have known about the numerous refusals. The RN failed to re-assess Patient #7's continued need for HHA services.	G 172		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure the registered nurse obtained and	G 176		8/13/10

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G 176	Continued From page 35 wrote a physician's order for treatments and notified the physician of changes in status for 4 of 40 patients (Patients #5, #33, #6 and #18). Findings include: Patient #5 Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity. On skilled nursing visit notes dated 5/18 and 5/25/10, the registered nurse (RN) documented the drainage from Patient #5's legs had a "urine odor." There was no documentation indicating the RN notified the physician of this change. Patient #33 Patient #33 was admitted on 5/25/10, with diagnoses including osteoarthritis of the hip, abnormal gait, anxiety and glaucoma. Patient #33's plan of care indicated the registered nurse was to see the patient two times a week for one week and then one time a week for eight weeks. According to a skilled nursing (SN) visit note dated 6/9/10, the registered nurse (RN) discharged Patient #33 that day. There was no documentation indicating the RN notified the physician SN goals had been met and obtained an order to discharge. There was no order in the clinical record to discharge the patient from SN seven weeks early.	G 176		

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G 176	Continued From page 36 Patient #6 Patient #6 was admitted on 4/27/10, with diagnoses including osteoarthritis and hypertension. For the certification period 4/27/10 through 6/25/10, the physician ordered home health aide (HHA) services two times a week for one week and three times a week for two weeks, to assist with personal care. According to the orders, the HHA was to visit Patient #6 two times the week of 4/27/10. There was no documented evidence in the patient record that HHA visit were made that week. A missed visit report dated 4/29/10, and signed by the HHA indicated a visit was not made on 4/29/10 as the patient had refused. There was no documentation as to why another visit was not made by the HHA that week. There was no documented evidence the physician was notified of the missed visits. Patient #18 Patient #18 was admitted on 5/1/10, with diagnoses including pressure ulcer, neurogenic bladder and quadriplegia. For the certification period of 5/1/10 through 6/29/10, the physician ordered home health aide (HHA) services three times a week for nine weeks beginning 5/5/10, to assist with personal care. Documentation in Patient #18's record indicated the HHA visited one time in the first week. There was no documentation indicating why two more visits were not made. There was no documentation the physician was notified of the missed visits.	G 176		

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G 176	Continued From page 37 Patient #18 was admitted to service with a urinary catheter in place. Documentation in the record indicated the Registered Nurse changed Patient #18's urinary catheter on 5/10 and 5/31/10. There was no documented evidence of a physician's order to change the urinary catheter.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on observation, record review and document review, the agency failed to ensure the registered nurse provided instructions regarding home safety and blood glucose monitoring to 1 of 40 patients (#5). Findings include: Patient #5 Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity. On 6/17/10 in the morning during a home visit, three sets of two conjoined electrical extension cords were observed stretched across the living room and passage way in Patient #5's house. This situation, combined with the patient's inability to adequately lift her feet while walking, created a substantial potential for a fall/injury.	G 177		8/13/10

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G 177	Continued From page 38 During the home visit, Patient #5 checked her blood glucose level. The patient pierced the tip of her finger without cleansing it with an alcohol swab or washing with soap and water. Once the blood was obtained the patient looked around for a tissue to apply to the site. Not finding any tissue, the patient indicated, "No tissue" and dipped/swished her finger in the basin of water (with Epsom salts) she had used to soak/clean her feet and legs earlier. Patient #5's clinical record lacked documented evidence the registered nurse had instructed the patient regarding these hazards. There was no evidence any teaching had been done regarding infection control. The agency's 12/1/05 Blood Glucose Monitoring policy, revised 5/1/06, revealed "...3. Instruct the patient to wash his or her hands with soap and warm water before the finger stick. Rinse and dry... 1. a. Instruct the patient to always wash his or her hands with soap and water before performing this test..."	G 177		
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must complete a performance review of each home health aide no less frequently than every 12 months. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to complete a performance review of a home health aide no less frequently than every 12 months for 1 of 1 home health aides (Employee #5).	G 214		8/13/10

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G 214	Continued From page 39 Findings include: On 6/22/10 in the afternoon, the director of clinical services (DCS) provided an employee information guide, last revised 7/1/03. According to the section entitled "annual evaluation", "employees will be evaluated by their supervisor on an as needed, periodic basis, but at least annually." On 6/15/10 in the afternoon, a review of active personnel files revealed Employee #5, a home health aide, was hired on 11/20/07. Employee #5's file contained performance evaluations dated 6/6/08 and 11/13/08. On 6/15/10 at 4:30 PM, the DCS was informed regarding Employee #5's lack of annual performance evaluations. On 6/18/10 in the afternoon, the office manager failed to provide the missing performance evaluations for Employee #5. On 6/22/10 in the afternoon, agency staff failed to provide the missing performance evaluations for Employee #5.	G 214		
G 215	484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by: Based on interview, record review, and document	G 215		8/13/10

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G 215	Continued From page 40 review, the agency failed to ensure home health aides (HHA) received at least 12 hours of in-service training during each 12 month period for 3 of 3 aides on the agency's personnel roster (Employees #5, #11, and #12). Findings include: On 6/15/10 at 11:15 AM, the Director of Clinical Services (DCS) was not able to provide documented evidence the HHAs received at least 12 hours of in-service training for the past 12 month period. The DCS indicated the agency relied on the aides to get outside training for which the agency would pay. On 6/15/10, documented evidence of 12 hours of in-service training was not found in Employee #5's personnel file. On 6/22/10, when asked for a policy in regards to HHA in-service training, the DCS provided a booklet titled "Employee Information Guide." Under the section "Inservice Education" it read, "...All Certified Home Health General Home Care Aides are required to have twelve hours of in service each calendar year. During the first year of employment, in service hours can be prorated."	G 215		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the	G 236		8/13/10

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G 236	Continued From page 41 attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to maintain an accurate and complete clinical record for 1 of 40 patients (Patient #14). Findings include: Patient #14 Patient #14 was admitted on 5/15/10, with diagnoses including malignant neoplasm main bronchus, diabetes mellitus, hypertension new onset, and hyperlipidemia new onset. On 5/16/10, the skilled nurse failed to document Patient #14's genitourinary, gastrointestinal, pain, and neuro/emotional status. On 5/21/10, the skilled nurse failed to document Patient #14's neuro/emotional status and failed to document his/her name and professional title. On 5/22/10, the skilled nurse failed to document Patient #14's respiratory, sensory, integumentary, genitourinary, gastrointestinal, and neuro/emotional status and failed to document his/her name and professional title. On 5/31/10, the agency transferred Patient #14 to a hospital. The skilled nurse failed to document a transfer summary and failed to document his/her name and professional title. On 6/21/10 at 2:39 PM, the Director of Clinical	G 236		

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G 236	Continued From page 42 Services (DCS) indicated skilled nurses were required to review each body system during each skilled visit as part of the overall assessment. The DCS was informed of the transfer document in Patient #14's clinical record and was asked to provide a completed version. After agreeing that the aforementioned transfer document was the correct form, the DCS provided another copy of the same transfer document without a transfer summary completed and without a clinician's signature and title. According to the agency's "patient care reports" policy, last revised on 3/1/09, clinical and progress notes were defined as "notation of a contact with a patient that is written legal documentation, signed and dated by a member of the health team...caregiver will sign each clinical note. Written notation dated and signed by health team members..."	G 236		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review, interview, and document review, the agency failed to ensure the Registered Nurse (RN) performed the initial assessment visit within 48 hours of referral for 1 of 40 sampled patients (Patient #9). Findings include: The agency's policy titled, "Assessments/Reassessments" with a revised date of 3/8/09 read, "...1. Completion of the	G 332		8/13/10

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G 332	Continued From page 43 comprehensive assessment: The initial assessment visit must be conducted either within 48 hours of the referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date..." Patient #9 Patient #9 was admitted on 11/9/09 with diagnoses including atrial fibrillation and hypertension. Documentation in the record indicated the patient was discharged from the acute care hospital on 11/5/09, at which time the agency received a referral for care. The RN conducted the initial comprehensive assessment on 11/9/09, four days after the receipt of the referral. There was no documentation in Patient #9's record why the RN did not conduct the initial visit within 48 hours of the receipt of the referral. There was no documentation the physician had ordered the initial assessment to be done later than the 48 hours of referral. On 6/16/10 at 3:15 PM, the Director of Clinical Services reviewed Patient #9's record and stated, "I don't know why the initial visit was done so late."	G 332		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	G 337		8/13/10

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G 337	Continued From page 44 This STANDARD is not met as evidenced by: Based on observation, record review, interview and document review, the agency failed to ensure staff regularly 1) performed comprehensive medication assessments; and 2) updated medication profiles to accurately reflect medications being taken by 7 of 40 patients (Patients #3, #5, #24, #33, #39, #16 and #18). Findings include: Patient #3 was admitted on 5/27/10 with diagnoses including gangrene of the left foot fifth toe and uncontrolled insulin dependent diabetes mellitus. According to the Plan of Care (POC), Patient #3 was to receive "Novalin (insulin) (subcut (subcutaneously) per sliding scale///with meals/) (N))." The actual sliding scale was not included in the POC. Patient #3's Medication Profile (MP) indicated "Novalin subcut - per sliding scale with meals for diabetes." The MP lacked documented evidence indicating the blood sugar ranges and how many units of insulin the patient should take depending on the blood glucose test results. Patient #3 had a peripherally inserted central catheter (PICC) which required flushing with normal saline (NS) before and after intravenous medication administration and blood draws. Patient #3's POC and MP lacked documented evidence of normal saline flushes. On 6/16/10 in the morning during a home visit, the MP was compared with the medications	G 337		

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Patient #3 had on hand and indicated were being taken.

Patient #3 revealed the following medications were being taken:

-- Soma 350 mg (milligrams) one tablet by mouth every 6 hours (for years)
-- Naproxen 500 mg one tablet by mouth twice a day with food
-- Loratadine 10 mg one tablet by mouth as needed for allergies (for years)
-- Lyrica 50 mg one tablet by mouth at bed time
-- Paxil 10 mg one tablet by mouth every morning (as of 6/8/10)
-- Famotidine 20 mg one tablet every three days as needed for indigestion

A skilled nursing visit note (SNVN) dated 6/14/10 included Soma, Lortab and Lyrica under the "Notes" section, along with the dose of each Patient #3 was taking.

As of 6/18/10, Patient #3's MP was not updated to include Normal Saline flushes, Soma, Lortab and Lyrica.

Patient #5

Patient #5 was admitted on 2/28/10 with diagnoses including congestive heart failure, bilateral lower extremity edema, hypertension and obesity.

On 6/17/10 in the morning during a home visit, Patient #5's medications were compared with the Plan of Care (POC) and Medication Profile (MP). The patient revealed she had not taken several of the medications listed on the POC and MP for two

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to three weeks because she "ran out."

Patient #5 indicated she started taking Vitamin D 50,000 international units one tablet every week as of 6/9/10. The MP lacked updates reflecting the addition of the supplement and the status of medications the patient was no longer taking.

Patient #16

Patient #16 was admitted on 5/7/10, with diagnoses including cervical disc degeneration and hypertension.

Patient #16's plan of care indicated the patient was to take Soma 350 milligrams by mouth every 12 hours "prn" (as needed). There was no clarification as to when the patient would need to take the medication.

Patient #24

Patient #24 was admitted on 6/17/10, with diagnoses including left hip fracture, right heel stage II pressure ulcer and anxiety.

On 6/17/10 in the afternoon,during a home visit Patient #24's medication profile (MP) prepared by the registered nurse (RN) was compared with an updated list the patient's spouse had. The MP indicated the patient was to take Omeprazole 20 milligrams one tablet every day. The spouse's list indicated the patient was taking Omeprazole 20 milligrams two tablets every day.

Patient #24's MP included Xanax 0.25 milligrams one tablet by mouth three times a day as needed for anxiety. The spouse's list did not include Xanax.

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Patient #33

Patient #33 was admitted on 5/25/10, with diagnoses including osteoarthritis of the hip, abnormal gait, anxiety and glaucoma.

Skilled nursing visit notes dated 5/29/10 and 6/9/10, revealed Patient #33's pain was being relieved with Tylenol.

On 6/17/10 in the afternoon, during a home visit Patient #33 had on hand and indicated he was taking fish oil, Calcium with Vitamin D, a senior formula multivitamin and fiber therapy.

Patient #33's plan of treatment (POT) and medication profile (MP) lacked documented evidence the patient was taking Tylenol, fish oil, Calcium with Vitamin D, a multivitamin and fiber therapy.

During the home visit on 6/17/10, Patient #33 indicated the Cosopt eye drops were administered twice a day. The POT and MP indicated the eye drops were administered once a day.

Patient #39

Patient #39 was admitted on 6/11/10 with diagnoses including Charcot ankle, insulin dependent diabetes mellitus and hypertension.

On 6/18/10 in the afternoon, during a home visit Patient #39's medication profile (MP) and plan of care (POC) were compared with medications the patient had on hand. The MP and POC indicated

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the patient was taking different doses of Gabapentin and Glyburide-Metformin than the prescription bottle labels revealed. The patient confirmed he was taking the medication in accordance with what was on the labels.

The agency's 11/1/05 Medication Profile policy revealed, " ... 3. The Medication profile will be updated or a new profile created upon Resumption of Care and/or Recertification. 4. Any new medications prescribed for the patient while on service with Western Home Care will be added to the patient Medication Profile."

Patient #18

Patient #18 was admitted on 5/1/10, with diagnoses including pressure ulcer, neurogenic bladder and quadriplegia. Documentation in the record indicated the patient was admitted to service with a urinary catheter in place.

During a home visit on 6/16/10 at 9 AM, the patient's current medication containers were compared with the Medication Profile (MP) dated 5/29/10, in Patient #18's record. The patient's spouse verified the patient was currently using the following medications which were not on the medication profile: Coreg 3.125 milligrams (mg) twice a day and Niacin 1000 mg once a day.